MEDI-CAL UPDATE Part 2
Billing and Policy
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Contents

Fluoride Varnish is a New Medi-Cal Benefit

Effective for dates of service on or after June 1, 2006, HCPCS code D1203 (topical application of fluoride [prophylaxis not included], child) is a Medi-Cal benefit for children younger than 6 years of age, up to three times in a 12-month period.

Because many dentists are not willing to see children this young, medical providers who routinely see pregnant women and young children offer the best hope for preventing and controlling tooth decay through the application of fluoride varnish. Physicians, nurses and medical personnel are legally permitted to apply fluoride varnish when the attending physician delegates the procedure and establishes protocol.

Reimbursement for code D1203 is $18, and includes materials and supplies needed for application.

This information is reflected in new manual section dental 1 (Part 2) and manual page hcpcsii 1 (Part 2).

New HCPCS Code for Azacitadine

Effective for dates of service on or after June 1, 2006, the current HCPCS code S0168 (azacitadine, 100 mg) will be replaced with code J9025 (azacitadine, 1 mg). All billing procedures and dosage limitations for azacitadine remain the same.

This updated information is reflected on manual replacement pages chemo 26 (Part 2) and inject list 3 (Part 2).

Intrauterine Contraception Reimbursement Rate Increase for Medi-Cal and Family PACT

Effective for dates of service on or after April 10, 2006, rates for HCPCS codes X1522 (ParaGard Intrauterine Device) and X1532 (Mirena Intrauterine System) have been increased. This increase affects both the Medi-Cal and Family PACT (Planning, Access, Care and Treatment) programs.

HCPCS Code	New Rate
X1522	$374.16
X1532	$420.33

This information is reflected on manual replacement pages non ph 7 and 10 (Part 2).

Transesophageal Echocardiography Modifiers Billing Clarification

Providers are reminded that Transesophageal Echocardiography procedures (CPT-4 codes 93312 – 93318) are reimbursable only when billed with the appropriate modifier.

Complete Service Billing with Modifier -ZS
Codes 93312, 93315 and 93318 must be billed using modifier -ZS. These codes are used when one physician has rendered the complete service, for example:

- Probe placement and image acquisition, interpretation and report; or
- Probe placement and image acquisition, interpretation leading to ongoing (continuous) assessment of cardiac pumping function and to therapeutic measures.

Professional Component Billing with Modifier -26
The professional component of codes 93313 and 93316 must be billed using modifier -26 when the billing physician has rendered only the professional component of the procedure (for example, placement of the probe).

Technical Component Billing with Modifier -TC
The technical component of codes 93314 and 93317 must be billed using modifier -TC when the billing physician has rendered only the technical component of the procedure (for example, image acquisition, interpretation and report).

This information is reflected on manual replacement pages cardio 8 (Part 2) and new manual sections cardio bil hcf 1 thru 5 (Part 2) and cardio bil ub 1 thru 5 (Part 2).

Surgical Implantable Devices Billing Reminder

Providers are reminded of the invoice requirements when billing for surgical implantable devices. The invoice must be on company letterhead from the implant supplier, not the hospital, and include:

- Recipient's full name
- Recipient's Medi-Cal number
- Physician's name
- Facility name where the implant procedure occurred
- Company contact information

Claims without all the above information will be denied.

References to this information were added to manual replacement pages surg aud 2 (Part 2), surg cardio 7 (Part 2) and surg nerv 6 (Part 2). Policy language is located on surg 5 (Part 2).

Contracted Inpatient Services Selective Hospitals Directory Update

The California Department of Health Services (CDHS) has updated the selective hospital contracting list for Health Facility Planning Areas (HFPAs). *This information is reflected on manual replacement pages contra 1 thru 15 (Part 2).*

New Blood Factor Billing Method for Pharmacy Providers Coming Soon

Effective for dates of service on or after July 1, 2006, pharmacy providers must bill Blood Factor and Anti-Hemophilia Factor products using National Drug Codes instead of billing "By Report." Providers can submit claims hard copy or electronically. However, providers who bill for California Children's Services (CCS) program-only, CCS/Healthy Families, Genetically Handicapped Persons Program (GHPP)-only eligible recipients, or for Medi-Cal/CCS/GHPP-eligible recipients with a CCS or GHPP Legacy or a CCS Service Authorization Request, must continue to bill hard copy with the required authorization by the Children's Medical Services Branch.

All other provider types must continue to bill using the "By Report" methodology currently in place using the *HCFA 1500* claim form.

Medi-Cal will continue to reimburse providers the lesser of the manufacturer's Average Selling Price plus 20 percent or the provider's usual and customary charge.

Provider manual pages regarding this policy will be updated in a future *Medi-Cal Update*.

Providers Receiving RAD Messages for Over-One-Year Claims

Effective May 1, 2006, providers will no longer receive acknowledgement, approval or denial letters for claims submitted more than 12 months from the month of service and that meet established late submission requirements. Such claims will be noted on a *Remittance Advice Details* (RAD) with a message indicating the status of the claim.

The policy described above applies only to original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining recipient eligibility, reversal of decisions on appealed *Treatment Authorization Requests* (TARs), Medicare/Other Health Coverage delays or other circumstances beyond the provider's control, and were subsequently sent to EDS' Over-One-Year Unit.

This updated information is reflected on manual replacement page hcfa sub 3 (Part 2).

Vision Care HIPAA Updates Effective July 1, 2006

Effective for dates of service on or after July 1, 2006, the following changes will be made to the Medi-Cal Vision Care Program, pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

- Convert Medi-Cal interim codes to national Health Care Procedure Coding System (HCPCS) Level II and Current Procedural Terminology (CPT-4) Level I codes.
- Eliminate all Medi-Cal qualifying codes and replace them with national CPT-4 and HCPCS modifiers. Additionally, modifiers X1 – X9 are no longer used for vision services.
- Replace the *Payment Request for Vision Care and Appliances* (45-1) claim form with the *HCFA 1500* claim form.
- Replace the current Treatment Authorization Request (TAR) process for medically necessary contact lenses, low vision aids and other non-Prison Industry Authority covered items using the 45-1 claim form, with a new process using the new 50-3 *Treatment Authorization Request* (TAR) form.

A detailed summary of policy changes is highlighted below. Refer to upcoming manual replacement pages, which will be published in the June *Medi-Cal Update*, for specific policy, billing and reimbursement information.

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Vision Care HIPAA Updates *(continued)*

CODE CONVERSION

Interim Code Conversion to National HCPCS and CPT-4 Codes

Conversion of interim procedure codes and qualifier codes for vision care services takes place July 1, 2006. All services provided on or after that date must be billed using the appropriate HCPCS or CPT-4 codes.

The table below outlines the conversion of the current Medi-Cal interim procedure codes to HCPCS and CPT-4 codes for Vision Care providers, effective for services performed on or after July 1, 2006.

Medi-Cal Interim Code	Description	HCPCS/ CPT-4 Code	Description
Z2700	Low vision evaluation, fitting and subsequent supervision, including six months follow-up care	CPT-4 92499	Unlisted ophthalmological service or procedure
Z2704	Detailed biomicroscopy slit lamp evaluation	None	Not a Medi-Cal benefit for services performed after June 30, 2006
Z2706	Contact lens examination	CPT-4 92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
Z2706	Contact lens examination	CPT-4 92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye

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Medi-Cal Interim Code	Description	HCPCS/ CPT-4 Code	Description
Z2706	Contact lens examination	CPT-4 92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes
Z2708	Out-of-office call	CPT-4 99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
Z2710	Mileage-per mile one way beyond a ten-mile radius from point of origin	None	Not a Medi-Cal benefit for services performed after June 30, 2006
Z2712	Diagnostic closure of the lacrimal punctum; by absorbable plug, one or more closures, incl. office visit	CPT-4 68761	Closure of the lacrimal punctum; by plug, each
Z2900	Contact lens, PMMA or gas permeable replacement	HCPCS V2500	Contact lens, PMMA, spherical, per lens
Z2900	Contact lens, PMMA or gas permeable replacement	HCPCS V2501	Contact lens, PMMA, toric or prism ballast, per lens
Z2900	Contact lens, PMMA or gas permeable replacement	HCPCS V2510	Contact lens, gas permeable, spherical, per lens
Z2900	Contact lens, PMMA or gas permeable replacement	HCPCS V2511	Contact lens, gas permeable, toric, prism ballast, per lens
Z2902	Contact lens, hydrophilic, replacement	HCPCS V2520	Contact lens, hydrophilic, spherical, per lens

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Medi-Cal Interim Code	Description	HCPCS/ CPT-4 Code	Description
Z2902	Contact lens, hydrophilic, replacement	HCPCS V2521	Contact lens, hydrophilic, toric or prism ballast, per lens
Z2904	Thermal hydrophilic lens care kit	None	Not a Medi-Cal benefit for services performed after June 30, 2006
Z2906	Bandage contact lenses	HCPCS V2599	Contact lens, other type (bandage contact lens)
Z2908	Contact lenses, extended wear, replacement	HCPCS V2513	Contact lens, gas permeable, extended wear, per lens
Z2908	Contact lenses, extended wear, replacement	HCPCS V2523	Contact lens, hydrophilic, extended wear, per lens
Z2910	Arm with adjustable pad	HCPCS V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2912	Front zyl (replace or repair)	HCPCS V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2914	Front combination or metal (replace or repair)	HCPCS V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2916	Temples-all types (replace)	HCPCS V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2918	Occluder, clip patch style	HCPCS V2770	Occluder lens, per lens
Z2920	Occluder, cup	HCPCS V2770	Occluder lens, per lens

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Medi-Cal Interim Code	Description	HCPCS/ CPT-4 Code	Description
Z2926	Headband	HCPCS V2799	Vision service, miscellaneous
Z2928	Nosepads, nosepad covers, temple covers (limited to one pair in each category)	HCPCS V2797	Vision supply, accessory and/or service component of another HCPCS vision code
Z2930	Dispensing fees-Single vision lens	CPT-4 92340	Fitting of spectacles, except for aphakia; monofocal
Z2930	Dispensing fees-Single vision lens	CPT-4 92352	Fitting of spectacles prosthesis for aphakia; monofocal
Z2932	Dispensing fees-Bifocal lens	CPT-4 92341	Fitting of spectacles, except for aphakia; bifocal
Z2932	Dispensing fees-Bifocal lens	CPT-4 92353	Fitting of spectacles prosthesis for aphakia; multifocal
Z2934	Dispensing fees-Trifocal lens	CPT-4 92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal
Z2936	Dispensing fees-Frame	None	Not a Medi-Cal benefit for services performed after June 30, 2006

Policy Requirements/Changes

- Vision service CPT-4 codes 99201 – 99215, 99241 – 99245 and HCPCS codes V2623 – V2629 maintain current policy and pricing.
- HCPCS code V2797 (vision supply, accessory and/or service component of another HCPCS vision code) cannot be billed with HCPCS code V2020 (frames, purchases) on the same date of service.
- CPT-4 code 99056 (out-of-office call) must be billed with one of the following CPT-4 codes (92002, 92004, 92012, 92014, 92310 – 92312, 99205 – 99215 and 92499) on the same date of service.
- CPT-4 codes 92225 (extended ophthalmoscopy) and 92250 (fundus photography) cannot be billed on the same date of service.
- CPT-4 code 92135 is reimbursable for optometrists.

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Vision Care HIPAA Updates *(continued)*

- Low vision evaluation must be billed with CPT-4 code 92499 (unlisted ophthalmological service or procedure).
- Bandage contact lenses must be billed with HCPCS code V2599 (contact lens, other type).
- Frame repairs and parts replacements must be billed with HCPCS code V2797 (vision supply, accessory and or service component of another HCPCS vision code). The new maximum allowable for HCPCS code V2797 includes both the repair service and frame part(s). Frame parts include nosepad arm with adjustable pad, nosepads, nosepad covers, temples and temple covers and frame front.
- Headbands must be billed with HCPCS code V2799 (vision service, miscellaneous).
- HCPCS codes V2020, V2100 – V2121, V2200 – V2221, V2300 – V2321, V2410 – V2430, V2500 – V2523, V2599, V2600, V2610, V2615, V2770, V2797 and V2799 must be billed with the following lens replacement codes on the ASC X12N 837 v.4010A1 transaction:
  - L1 (general standard of 20 degree or .5 diopter sphere or cylinder change met)
  - L2 (replacement due to loss or theft)
  - L3 (replacement due to breakage or damage)
  - L5 (replacement due to medical reason)

MODIFIERS

Modifiers Replace Qualifying Codes

Effective for dates of service on or after July 1, 2006, Medi-Cal qualifying codes currently used on a *Payment Request for Vision Care and Appliances* (45-1) claim form will be replaced with national modifiers.

The following modifiers are required with the CPT-4 and HCPCS codes listed below:

CPT-4 Code	Modifier
68761	SC, E1, E2, E3, E4
92310	22, SC
92311	22, SC
92312	22, SC
92340	NU, RP
92341	NU, RP
92342	RP, KX
92352	NU, RP
92353	NU, RP
99056	22

HCPCS Code	Modifier
V2020	NU, RP
V2100 – V2121	NU, RP
V2200 – V2221	NU, RP
V2300 – V2321	RP, KX
V2410 – V2430	NU, RP
V2500	NU, RP
V2501	NU, RP
V2510	NU, RP

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HCPCS Code	Modifier
V2511	NU, RP
V2513	NU, RP
V2520	NU, RP
V2521	NU, RP
V2523	NU, RP
V2599	LT, RT
V2600	NU, RP
V2610	NU, RP
V2615	NU, RP
V2770	NU, RP
V2797	RP
V2799	NU, RP

Effective for dates of service on or after July 1, 2006, the following CPT-4 and HCPCS codes and national modifiers information must be present on the *HCFA 1500* claim form:

- All procedure codes for eye appliances and eyeglass dispensing must be billed with an appropriate modifier. Modifiers required for billing eye appliances include -NU (new equipment), -RP (repair/replacement) and -KX (specific required documentation on file).
  - Use modifier -NU when supplying or dispensing eye appliances to recipients with no prior eye appliance.
  - Modifier -RP is used to indicate repair or replacement of prior eye appliances.
  - Since trifocal lenses are covered only for recipients who are current trifocal wearers, modifier -KX is billed in conjunction with -RP for trifocal lenses (HCPCS codes V2300 – V2321) and the dispensing of trifocal lenses (CPT-4 code 92342) to indicate that the provider has documentation on file stating that the recipient is a current trifocal wearer and not a first-time wearer.
- When billing for CPT-4 code 68761 (closure of the lacrimal punctum, by plug, each), providers must use modifier -SC (medically necessary service/supply) when temporary collagen punctal plugs are used and modifiers -E1 (upper left, eyelid), -E2 (lower left, eyelid), -E3 (upper right, eyelid) and -E4 (lower right, eyelid) when permanent silicone punctal plugs are used. Each of these listed modifiers must be billed with a quantity of 1.
- Modifiers -22 (unusual procedural services) and -54 (surgical care only) are allowable with CPT-4 codes 65210 (removal of foreign body, external eye, conjunctival embedded), 67820 (correction of trichiasis) and 67938 (removal of foreign body, eyelid), but are not required for reimbursement.
- Either modifier -22 or -SC may be billed with CPT-4 codes 92310 – 92312.
- Because CPT-4 code 68761 and HCPCS code V2599 may require multiple modifiers to describe the service, providers must use separate claim lines for each procedure code/modifier combination.
- All required modifiers, with the exception of -RP and -KX, must be billed on a single claim line.
- Modifiers X1 – X9 are no longer used for vision services.

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DIAGNOSIS CODES (ICD-9)

CPT-4 Codes and HCPCS Codes and Corresponding ICD-9 Codes

Effective for dates of service on or after July 1, 2006, ICD-9 diagnosis codes must be present and valid on all claims for the following CPT-4 and HCPCS codes. Failure to supply a valid ICD-9 code will result in denial of the claim. Refer to the *Professional Services: Diagnosis Codes* section in upcoming manual replacement pages included in the June *Medi-Cal Update* for a list of procedures and the required corresponding ICD-9 diagnosis codes:

CPT-4 Code	Description
65205	Removal of foreign body, external eye, conjunctival superficial
65210	Removal of foreign body, external eye, conjunctival embedded
65220	Removal of foreign body, corneal, without slit lamp
65222	Removal of foreign body, corneal, with slit lamp
67820	Correction of trichiasis
67938	Removal of foreign body, eyelid
68761	Closure of lacrimal punctum
68801	Dilation of lacrimal punctum
92020	Gonioscopy
92081 – 92083	Visual field examination
92100	Serial tonometry
92135	Scanning computerized ophthalmic diagnostic imaging
92225	Extended ophthalmoscopy
92250	Fundus photography

HCPCS Code	Description
V2599	Bandage contact lenses
V2710	Slab off prism
V2744	Tint, photochromic
V2745	Tint, solid, gradient, or equal
V2755	Ultra Violet (UV)

To justify payment, the following primary and/or secondary ICD-9 diagnosis codes must be present on the claim when billing ophthalmic lenses and frames and lens dispensing fees for the conditions specified below:

- When two pair of single vision eyeglasses are prescribed in lieu of bifocals for recipients 38 years of age and older:
  - Primary
    - ❖ 367.4 (presbyopia)
  - Secondary
    - ❖ 368.1 (subjective visual disturbance)
    - ❖ 368.13 (visual discomfort)
    - ❖ 368.14 (visual distortions in shape and size)
    - ❖ 368.15 (other visual distortions and entopic phenomena)
    - ❖ 368.16 (psychophysical visual disturbances)
    - ❖ 368.8 (other specified visual disturbances)
    - ❖ 368.9 (unspecified visual disturbance)

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- When bifocals or two pair of single vision eyeglasses are prescribed in lieu of bifocals for recipients younger than 38 years of age:
  - 367.50 (disorders of accommodation)
  - 367.51 (paresis of accommodation)
  - 367.52 (total or complete internal ophthalmoplegia)
  - 367.53 (spasm of accommodation)
  - 367.9 (unspecified disorder of refraction and accommodation)
  - 378.35 (accommodative component in esotropia)
  - 378.84 (convergence excess or spasm)

A second eye examination with refraction within 24 months is covered only when a sign or symptom indicates a need for this service. Claims billed with CPT-4 codes 92004 and 92014 must include appropriate ICD-9 diagnosis codes that justify the examination on the claim. This policy applies whether the claim is submitted by the provider of the prior examination or by a different provider.

Note: Only two ICD-9 diagnosis codes are acceptable in the *Diagnosis or Nature of Illness or Injury* field (Box 21) of the *HCFA 1500* claim form. Providers must use separate claim forms when multiple procedures that require diagnosis codes are billed on the same date of service.

Required Documentation

Although many procedure codes can be medically justified with ICD-9 diagnosis codes only, the following CPT-4 codes require further medical justification to be included with the claim for reimbursement. Refer to upcoming manual replacement pages included with the June *Medi-Cal Update* for detailed instructions about required documentation.

CPT-4 Code	Description
65210	Removal of foreign body, external eye; conjunctival embedded
67938	Removal of embedded foreign body, eyelid
68761	Closure of the lacrimal punctum
68801	Dilation of the lacrimal punctum
92100	Serial tonometry
92225	Extended ophthalmoscopy
92250	Fundus photography

CPT-4 Code	Description
92310 – 92312	Contact lens evaluations
92499	Unlisted ophthalmological service or procedure
99205, 99215	Evaluation and Management
99506	Out-of-Office call

In addition to thoroughly documenting in the medical chart, providers may be required to also submit documentation with the claim indicating the reason additional benefits are warranted when frequency limits are exceeded for all ophthalmological services and eye appliances.

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CLAIM FORM CONVERSION TO THE *HCFA 1500*

Paper Claim Submitters

Effective for dates of service on or after July 1, 2006, the *Payment Request for Vision Care and Appliances* (45-1) claim form will no longer be accepted. All vision services must be billed on the *HCFA 1500* claim form. Instructions for completing the *HCFA 1500* claim form will be included in the upcoming manual replacement pages with the June *Medi-Cal Update*.

The following fields currently required on the 45-1 will no longer be required on the *HCFA 1500* claim form:

- ***Refractionist's Signature***. Providers that fill another provider's prescription must keep a copy of the prescription in the recipient's medical record, which must be made available for state review if requested.
- ***Date of Appliance Delivered***. Although the *Date of Appliance Delivered* is no longer a requirement, providers must document in the medical record that the eye appliance was delivered to the recipient. Documentation must include the date that eye appliances were delivered and the recipient, legal representative or guardian's signature.
- ***Date Billed***

Institutional Providers Billing Vision Services

CDHS will no longer accept the Medi-Cal proprietary *Payment Request for Vision Care and Appliances* (45-1) claim form for vision services billed for dates of service on or after July 1, 2006. All providers, including institutional providers, must bill using the *HCFA 1500* claim form when billing paper claims.

New 50-3 TAR Form

A new 50-3 *Treatment Authorization Request* (TAR) form has been created as a result of the discontinuance of the *Payment Request for Vision Care and Appliances* (45-1) claim form previously used to request prior authorization for eye appliances. Effective for dates of service on or after July 1, 2006, all prior authorization requests must be submitted on this new 50-3 TAR form. Instructions for completing the 50-3 TAR form and how to request authorization and bill for approved services will be included in the upcoming manual replacement pages with the June *Medi-Cal Update*.

All prior authorization requests for the following HCPCS codes must be submitted on the new 50-3 TAR form:

HCPCS Code	Description
V2500	Contact lens, PMMA, spherical, per lens
V2501	Contact lens, PMMA, toric or prism ballast, per lens
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric or prism ballast, per lens

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HCPCS Code	Description
V2513	Contact lens, gas permeable, extended wear, per lens
V2520	Contact lens, hydrophilic, spherical, per lens
V2521	Contact lens, hydrophilic, toric or prism ballast, per lens
V2523	Contact lens, hydrophilic, extended wear, per lens
V2600	Hand held low vision aids and other nonspectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescope and other compound lens system
V2799	Vision service, miscellaneous

Note: HCPCS codes V2600, V2610, V2615 and V2799 require a TAR with a special handling description when billing limitations are exceeded.

All prior authorization requests for the following CPT-4 codes must be submitted on the new 50-3 TAR form:

CPT-4 Code	Description
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes

Note: Currently, prior authorization is not required for CPT-4 codes 92310 – 92312 and for daily wear contact lenses prescribed for certain conditions. The new TAR requirement for CPT-4 codes 92310 – 92312 and all contact lens codes (V2500 – V2523) regardless of diagnosis is a change from current policy.

Special Handling Descriptions
Some vision procedure codes that do not normally require a TAR may be denied due to various billing limitations. In order to prevent the denial of a claim, a TAR must be submitted on the 50-3 TAR form with the appropriate special handling description indicated in the *Medical Justification* field. The new special handling descriptions are as follows:

- Exceeded billing dollar amount
- Exceeded billing frequency limit
- Usage is for non-standard diagnosis

The current authorization process requires that an original 45-1 claim form be mailed to the Vision Care Policy Unit (VCPU) for authorization. Effective for vision services performed on or after July 1, 2006, the 50-3 TAR form and associated documentation can be mailed or faxed to:

California Department of Health Services
Vision Care Policy Unit
MS 4600
P.O. Box 997413
Sacramento, CA 95899-7413

VCPU Fax Number: (916) 552-9077

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Since this new TAR process allows the provider the ability to submit and receive the 50-3 TAR by fax, it will improve the response and turnaround time for authorizations. Upon completion of the authorization review process, the VCPU will fax (if a valid fax number is included on the form) or mail back the 50-3 TAR form with a decision (Approved as Requested, Approved as Modified, Denied or Deferred). All TARs are assigned a TAR Control Number (TCN) and Pricing Indicator (PI) on the 50-3 TAR form. Claims for approved services must include a valid TCN and PI for payment. The assigned TCN and PI are also required for resubmission of denied and deferred TARs.

Vision Care Electronic Claim Form Changes Effective July 1, 2006

Conversion to HIPAA-Compliant Electronic Claim Transactions
Effective July 1, 2006, the Vision CMC proprietary claims transaction format will no longer be accepted for vision services, regardless of the date services were performed.

When converting to the ASC X12N 837 v.4010A1 transaction, the Vision Data Specifications should be used for claims with dates of service prior to July 1, 2006. For dates of service on or after July 1, 2006, the Medical Data Specifications (part of the *837 v.4010A1 Health Care Claim Companion Guide*) have been updated to include the required segments for vision claims.

The companion guides are available on the Medi-Cal home page at **www.medi-cal.ca.gov**. Click "HIPAA" and then "ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications."

Electronic Claim Submission Using the Internet
Available for claims with dates of service on or after July 1, 2006, the HIPAA-compliant 837 Internet Professional Claim Submission (IPCS) Online Claim Form will be updated to give vision care providers an alternate method of submitting electronic claims in real-time through the Medi-Cal Web site. The online claim form will be updated to include new fields necessary for billing vision services. The *Internet Professional Claim Submission (IPCS) User Guide* will be updated to reflect these changes.

The IPCS system allows users to submit single vision service claims in real-time. The IPCS system does not perform online adjudication nor does it accept crossover claims. Claims submitted successfully receive a Claim Control Number (CCN) on the host response screen. If the IPCS system detects errors, the user will receive a "CLAIM REJECTED" message on the host response screen, and the claim can be edited to correct these errors before resubmitting. Submitted claims enter the daily batch cycle of the Medi-Cal claims processing system.

The IPCS system allows faster, more efficient, data exchange between providers and the California Department of Health Services (CDHS).

To use the IPCS system, providers must have both of the following:

1. A *Medi-Cal Point of Service (POS) Network/Internet Agreement* form on file with CDHS for each provider number that is used to bill. If providers currently have valid forms on file, no additional updates are needed. Providers can download the form from the Medi-Cal Web site by clicking the "Forms" link on the home page, then clicking "Medi-Cal Point of Service (POS) Network/Internet Agreement." Providers should print the form, complete, sign and return it to Medi-Cal at the address shown on the bottom of the form.
2. A valid Computer Media Claims (CMC) submitter ID and password. To obtain or update your ID and password, complete the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHS 6153), which can be downloaded from the "Forms" page of the Medi-Cal Web site. Check the "Internet" box in the Real Time Submission Type section, check Medical/Allied Health (05) and enter 4010X098 where indicated in the ANSI X12 837 Version section.

Please see **Vision Care Electronic Claim Form Changes**, *page 15*

Vision Care Electronic Claim Form Changes, *(continued)*

Note: Submitters with a current, valid CMC submitter ID must still submit the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* to add the IPCS application to their list of available Internet options.

As of July 1, 2006, only professional medical and vision claims can be submitted using IPCS. Institutional claims cannot be submitted.

Additional Resources
Recent *Medi-Cal Updates* have provided detailed information about the upcoming changes to the Vision Care Program. To review the articles listed below, click the "Vision Care" link in the Provider Bulletins area of the Medi-Cal home page and then click the "Part 2 – Billing and Policy" link.

April 2006: "New Vision Care Treatment Authorization Request (TAR) Process Effective July 1, 2006"

March 2006: "Convert Early to HIPAA-Compliant Electronic Claim Transactions"

February 2006: "Upcoming Vision Care Changes in July 2006"

January 2006: "Conversion of Vision Care Interim Billing Codes and Modifiers and Notice of Public Comment Period"

For more information, call the Telephone Service Center (TSC) at 1-800-541-5555, from 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200. To learn more about other vision care-related HIPAA changes, refer to the "HIPAA News" section of the Medi-Cal Web site.

CCS Service Code Groupings Update

Effective for dates of service on or after July 1, 2006, numerous codes have been end-dated within the California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02 and 07. These end-dated codes appear in bold with a strike through the entire code.

In addition, retroactive for dates of service on or after July 1, 2004, codes have been added to SCGs 01, 02 and 05. These codes are bold and underlined.

It is important to note that on these manual pages SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01, 02 and 03. These same "rules" apply to end-dated codes.

This information is reflected on manual replacement pages cal child ser 1, 5, 6, 11 thru 18 and 21 (Part 2).

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications.*

Additions, effective May 1, 2006

Drug	Size and/or Strength
DEXMETHYLPHENIDATE HCL	
* Capsules, extended release	5 mg
	10 mg
	20 mg

* Restricted to use in Attention Deficit Disorder in individuals between 4 and 16 years of age.

(NDC labeler code 00078 [Novartis Pharmaceutical Corporation] capsules only).

Please see **Contract Drugs**, *page 16*

Contract Drugs *(continued)*

Additions, effective May 1, 2006 (continued)

Drug	**Size and/or Strength**
IBANDRONATE SODIUM	
Tablets	150 mg

Changes, effective May 1, 2006

Drug	**Size and/or Strength**	
ALBUTEROL SULFATE		
+ Tablets or capsules	2 mg	
+ Long-acting tablets	4 mg	
	4 mg	
	8 mg	
~~**(NDC labeler code 65473 [Odyssey Pharmaceuticals, Inc.] for long-acting tablets only.)**~~		
Inhaler (without chlorofluorocarbons as the propellant)	6.7 Gm	
Solution for inhalation	0.5 %	20 cc
Solution for inhalation, premixed	0.083 %	
	1.25 mg/3 cc	
	0.63 mg/3 cc	
Liquid	2 mg/5 cc	
Capsules for inhalation with inhalation device	Package containing 96 or 100 capsules and one inhalation device	
*** ARIPIPRAZOLE**		
Tablets	5 mg	
	10 mg	
	15 mg	
	20 mg	
	30 mg	
*** Restricted to individuals 6 years of age and older.**		
***** BORTEZOMIB		
Powder for injection	3.5 mg/vial	
***** ~~Prior authorization always required.~~		

+ Frequency of billing requirement

Please see **Contract Drugs**, *page 17*

Contract Drugs *(continued)*

Changes, effective May 1, 2006 (continued)

Drug	**Size and/or Strength**	
* CHLORPROMAZINE		
Injection	25 mg/cc	1 cc
		2 cc
		10 cc
+ Tablets	10 mg	
	25 mg	
	50 mg	
	100 mg	
	200 mg	
Liquid	10 mg/5cc	
	30 mg/cc	
	100 mg/cc	
Suppositories	25 mg	
	100 mg	
*** Restricted to individuals 6 years of age and older.**		
* CLOZAPINE		
Tablets	25 mg	
	100 mg	
Tablets, orally disintegrating	25 mg	
	100 mg	
*** Restricted to individuals 6 years of age and older.**		
* FLUPHENAZINE		
Injection	2.5 mg/cc	10 cc
	25 mg/cc	
+ Tablets	1 mg	
	2.5 mg	
	5 mg	
	10 mg	
Liquid	0.5 mg/cc	
Liquid concentrate	5 mg/cc	
*** Restricted to individuals 6 years of age and older.**		

+ Frequency of billing requirement

Please see **Contract Drugs**, *page 18*

Contract Drugs *(continued)*

Changes, effective May 1, 2006 (continued)

Drug	**Size and/or Strength**	
***** IMATINIB MESYLATE		
Capsules	100 mg	
Tablets	100 mg	
	400 mg	
*** ~~Prior authorization always required.~~**		
* MESORIDAZINE		
Injection	25 mg/cc	1 cc
+ Tablets or capsules	10 mg	
	25 mg	
	50 mg	
	100 mg	
Liquid	25 mg/cc	120 cc
*** Restricted to individuals 6 years of age and older.**		

+ Frequency of billing requirement

Please see **Contract Drugs**, *page 19*

Contract Drugs *(continued)*

Changes, effective May 1, 2006 (continued)

Drug	Size and/or Strength	
* OLANZAPINE		
Tablets	2.5 mg	
	5 mg	
	7.5 mg	
	10 mg	
	15 mg	
	20 mg	
Tablets, orally disintegrating	5 mg	
	10 mg	
	15 mg	
	20 mg	
*** Restricted to individuals 6 years of age and older.**		
* PERPHENAZINE		
Injection	5 mg/cc	1 cc
+ Tablets	2 mg	
	4 mg	
	8 mg	
	16 mg	
Liquid	16 mg/5cc	
*** Restricted to individuals 6 years of age and older.**		
* QUETIAPINE FUMARATE		
Tablets	25 mg	
	100 mg	
	200 mg	
	300 mg	
*** Restricted to individuals 6 years of age and older.**		
* RISPERIDONE		
Tablets	0.25 mg	
	0.5 mg	
	1 mg	
	2 mg	
	3 mg	
	4 mg	
Solution	1 mg/cc	
*** Restricted to individuals 6 years of age and older.**		

+ Frequency of billing requirement

Please see **Contract Drugs**, *page 20*

Contract Drugs *(continued)*

Changes, effective May 1, 2006 (continued)

Drug	Size and/or Strength
* THIORIDAZINE	
+ Tablets	10 mg
	15 mg
	25 mg
	50 mg
	100 mg
	150 mg
	200 mg
Liquid	30 mg/cc
Concentrate	100 mg/cc

*** Restricted to individuals 6 years of age and older.**

* TRIFLUOPERAZINE	
Injection	2 mg/cc
+ Tablets	1 mg
	2 mg
	5 mg
	10 mg
Liquid	10 mg/cc

*** Restricted to individuals 6 years of age and older.**

* ZIPRASIDONE HCL	
Capsules	20 mg
	40 mg
	60 mg
	80 mg

*** Restricted to individuals 6 years of age and older.**

Please see **Contract Drugs**, *page 21*

Contract Drugs *(continued)*

Changes, effective June 1, 2006

Drug	**Size and/or Strength**
* CELECOXIB	
Capsules	100 mg
	200 mg

~~* Prior authorization always required.~~ **Restricted to:**

1. **use for arthritis for claims submitted with dates of service from June 1, 1999 through May 31, 2006; or**
2. **use for rheumatoid arthritis, juvenile arthritis, or ankylosing spondylitis and concurrent use of a DMARD for claims submitted with dates of service on or after June 1, 2006.**

+ Frequency of billing requirement

The following Code 1 restrictions for *Drugs: Contract Drugs List Part 1 – Prescription Drugs* have been updated:

Brimonidine Tartrate	Morphine Sulfate	Repaglinide
Ciclopirox	Niacin	Salmeterol Xinafoate
Clindamycin Phosphate	Oxandrolone	Somatropin (rDNA Origin)
Enfuvirtide	Oxiconazole Nitrate	Tolcapone
Latanoprost	Papain-Urea-Chlorophyllin Copper Complex Sodium	Zaleplon
Metronidazole		

Instructions for Manual Replacement Pages Part 2

May 2006

General Medicine Bulletin 382

Remove and replace:	*Contents for General Medicine Billing and Policy* iii/iv
Remove and replace:	cal child ser 1/2, 5/6, 11 thru 18, 21/22 cardio 7/8
Insert new section after the end of the *Cardiology* section:	cardio bil hcf 1 thru 5
Remove and replace:	chemo 25/26 contra 1 thru 15
Insert new section after the end of the *Contracted Inpatient Services: Selected Hospitals Directory*	dental 1
Remove and replace:	hcfa sub 3/4, 5/6 * hcpcs ii 1/2 * hcpcs iii 1/2 * inject list 3/4
Remove:	modif app 1 thru 7
Insert:	modif app 1 thru 10 *
Remove and replace:	non ph 7 thru 10 oth hlth cpt 1/2 * path cyto 1/2 * surg aud 1/2 surg cardio 7 surg digest 1/2 * surg nerv 5/6